Supreme Court, U.S.
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No. 87-1037

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

DEERE & COMPANY,
Petitioner,

vs.

T. J. KENNEDY, *et al.*,
Respondents.

RESPONSE TO PETITION FOR A WRIT OF CERTIORARI FROM THE ILLINOIS SUPREME COURT

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QUESTION PRESENTED FOR REVIEW

Contrary to the representation of Petitioner, the only issue presented for review is: Does an assignee designated by a participant under an employee health care plan have standing to sue the plan administrator directly for those benefits under ERISA?

LIST OF PARTIES AND RULE 28.1 LIST

The parties to the proceedings were the petitioner, Deere & Company, and the Respondents, T. J. Kennedy, D.C.; Terry L. Burke d/b/a Burke Chiropractic Clinic; Michael H. W. Hurst d/b/a Hurst Chiropractic Center; Stephen Miner, D.C. d/b/a Miner Chiropractic Clinic; and James P. Woods, D.C. In the trial court, the suit of Harlow E. Wells, D.C. had been consolidated with the suits of the other respondents named above, but Wells voluntarily dismissed his suit against the petitioner on November 16, 1984.

The subsidiaries of Deere & Company as listed by the petitioner, while impressive, are not parties to this action.

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Respondents agree to the Statutes as submitted by the Petitioner herein.

STATUTES INVOLVED

Sec. 502 (a)(1)(B) of ERISA [29 U.S.C. sec. 1132(a)(1)(B)]:

A civil action may be brought —

(1) by a participant or beneficiary * * *

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan * * *

Title 29 U.S.C., §1002(8):

(8) the term "beneficiary" means *a person designated by a participant,* or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

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OPINIONS BELOW

Respondents agree to the Opinions Below as submitted by the Petitioner herein.

JURISDICTION

Respondents agree to the Jurisdiction as stated by the Petitioner herein.

STATEMENT OF THE CASE

Respondents are required to correct certain blatant misstatements of fact in this portion of Petitioner's submission.

This *is* a suit charging in Count I that Petitioner violates 29 U.S.C. §1140, by paying certain health care providers, e.g. physical therapists, for services identical to that provided by respondents; and then refusing to pay respondents.

This *is* a claim that respondents are entitled to be paid for outpatient physical therapy under a provision in the plan that states:

> "Outpatient physical therapy benefits will be payable for services performed for a period of 60 treatment days when prescribed by a physician for a specified condition resulting from disease or injury or prescribed immediately following surgery related to the condition and when the physical therapy is performed in a nursing home or *other facilities such as rehabilitation centers having comprehensive physical therapy facilities.*" (emphasis supplied)

This dispute is *not* about the payment of reasonable and customary costs of service.

The Deere & Company plan does *not* provide for payment of "reasonable and customary cost of services given by chiropractors;" but does provide for payment of physical therapy services which Deere has refused to do for respondents.

This dispute is *not* about "chiropractors (who) assert that the value of their services . . . far exceeded the amounts allowed under the plan.

It is *not* a "sharp disagreement between petitioner and respondents as to whether respondents were overcharging for their services."

We commend the Petition to you with this correction of the nature of the dispute. One wonders why the true nature of the conflict needs obfuscation?

REASONS FOR DENYING THE WRIT

THE DECISION OF THE ILLINOIS SUPREME COURT FOLLOWS THE PLAIN LANGUAGE OF ERISA.

THE STATUTE SPECIFICALLY PROVIDES THAT A "PARTICIPANT" MAY "DESIGNATE" A "BENEFICIARY.". BOTH THE "PARTICIPANT" AND THE "BENEFICIARY" MAY SUE TO COLLECT BENEFITS IN FEDERAL OR STATE COURT.

NO CONFLICTS EXISTS IN THE EXISTING APPELLATE OPINIONS. ALL ARE IN ACCORD SUPPORTING STANDING TO SUE.

NO INTERPRETATION OF THE PLAIN LANGUAGE OF THE STATUTE IS REQUIRED. NO AMBIGUITY NEED BE RESOLVED. NO EXPANSION OF UNINTENDED REMEDIES EXISTS.

A DECISION RECOGNIZING THE EXPRESS LANGUAGE OF THE STATUTE DOES NOT POSE A FEDERAL QUESTION OF SUCH IMPORT AS TO MERIT THE INTERVENTION OF THIS AUGUST COURT.

A DECISION THAT RESULTS IN THE EMPLOYEE BEING GRANTED PRECISELY THE BENEFIT THE TRUST IS DESIGNED TO PROVIDE SHOULD NOT BE QUESTIONED.

NO FLOOD OF LITIGATION HAS RESULTED. ERISA'S LANGUAGE HAS BEEN THE SAME SINCE 1974, AND NO SUCH "FLOOD" HAS INUNDATED THE COURTS. IN FACT, THE ONLY TIME THERE WILL BE ANY LITIGATION IS WHEN A PLAN REFUSES TO PAY AS AGREED. THIS SUIT IS *NOT* ABOUT OVERCHARGES. IT IS ABOUT DISCRIMINATION IN THE PAYMENTS FOR PHYSICAL THERAPY IN VIOLATION OF THE PLAN PROVISIONS AND ERISA.

ERISA states:

Title 29, U.S.C., §1002(8):

> "(8) the term "beneficiary" means *a person designated by a participant,* or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder."

Title 29, U.S.C. §1132(a)(1)(B):

> "Persons empowered to bring a civil action. A civil action may be brought —
>
> (1) By a participant or *beneficiary* —
>
> (A) for the relief provided for in subsection (c) of this section or,
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . ."

A federal appellate court, and now the Supreme Court of Illinois, following the express language of the statute, have held that plaintiffs have standing to pursue their claims.

No conflict of decisions exists. All appellate decisions on point, federal and state, are in accord. Thus, Supreme Court rule 17.1(a) and (b) are no basis to grant the Petition in this cause *Misic v. Building Services Employees Health & Welfare Trust,* 789 F.2d 1374 (9th Cir. 1986; *Kennedy, et al v. Deere & Company,* 118 Ill.2d 69, 514 NE2d 171 (1987)

Rule 17.1(c) remains. Petitioner states that because of the broad far-reaching effect of this decision, there must be then an important question of federal law which this court should settle.

The provisions of ERISA have been the same since 1974. The "flood" of litigation which petitioner predicts has failed to materialize in fourteen years.

It stretches the imagination to think that Congress failed to consider this issue in the drafting process.

> "The assumption of inadvertant omission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated and interdependent remedial scheme, which is in turn part of a 'comprehensive and reticulated statute'." *Massachusetts Mutual Life Insurance Company v. Russell,* 105 S.Ct. 3085 (1985).

Congress outlawed assignment of pension benefits and not health care benefits. Clearly, the subject of assignment was considered.

In point of fact, the only time litigation will arise is when the plan administrator fails to pay as agreed. We suggest that is exactly when litigation is proper, and the employee will be the one protected as ERISA seeks to do.

As stated, this dispute is *not* about overcharging.

It is about a plan administrator refusing to pay as agreed.

Count I alleges that Defendant violated 29 U.S.C. §1140. That section provides:

> "It shall be unlawful for any person to . . . discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan . . . for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan . . ."

Plaintiffs allege that Defendant pays medical doctors, physical therapists, hospitals and other health care providers at different and higher rates, than it will pay Plaintiffs for identical services.

Count II deals with payment for outpatient physical therapy. The plan states:

> "Outpatient physical therapy benefits will be payable for services performed for a period of 60 treatment days when prescribed by a physician for a specified condition resulting from disease or injury or prescribed immediately following surgery related to the condition and when the physical therapy is performed in a nursing home or *other facilities such as rehabilitation centers having comprehensive physical therapy facilities.*" (emphasis supplied)

Plaintiffs allege they are entitled to be paid for services provided pursuant to this section, and Defendant has refused to do so.

This court, faced with the many weighty matters before it, need not concern itself with the few occasions when a plan administrator attempts to arbitrarily ignore its obligations to the employees it is charged to protect. The remedy is available as provided by Congress. No confusion needing your intervention exists. No damage to the detriment of the protected employee will result, and the administrator will be called upon to respond only when it violates its fiduciary duty to the employee.

CONCLUSION

There certainly is no conflict between the decision sought to be reviewed and a decision of this Court, or any other court.

No need to exercise supervisory authority exists; and despite the cries of doom and gloom put forth by the petitioner, one must remember that the sole issue that has been decided in this matter is that a participant in a health care plan can assign his right to payment to a health care provider. Then, on the basis of that assignment, pursuant to the time-honored rules in regard to same, the provider may bring an action to enforce his right to payment.

No cause of action was "created" by this decision. The cause of action was "created," if you will, by the express language of ERISA which:

> (1) states that a participant may designate a beneficiary who is or may be one who will receive a benefit under the plan, and
>
> (2) grants a beneficiary the right to sue to obtain his benefits under the plan and
>
> (3) grants concurrent jurisdiction in the State court to do so.

This language, when reviewed in light of the general law of assignments, makes the decision inescapable.

There, further, is no evidence in the record that would indicate any deleterious effect upon employers or their health care plans. All that has been decided here is that an employer who sets up a contractual arrangement allowing the assignment of the right to payment may expect that the assignee will seek to enforce the assignment. Thus, the assignee will not be without remedy.

Likewise, there is no evidence to support petitioner's claim of a "flood of litigation." Should such a "flood" result, which is unlikely, it could come about for only two reasons:

(1) The employers are not paying according to the contractual provisions of their plan; thus, *they should be called to task*; or

(2) Plaintiffs would be filing actions that could be sanctioned under Codes of Civil Procedure. Such sanction should be a sufficient deterrent to such activity.

Further, this Court in the past has never been intimidated by such a "flood of litigation" argument. One remembers well the response to such allegations that states: if the rights of employees are being ignored or willfully violated, and a "flood of litigation" be necessary to restore and protect those rights — so be it!

Respectfully submitted,

T.J. Kennedy, D.C.;
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Michael H.W. Hurst d/b/a Hurst Chiropractic Center;
Stephen Miner, D.C. d/b/a Miner Chiropractic Clinic; and
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